

Transitional Employment Plan

Employee Name	Department
Supervisor	Regular Job Title/Class

Physical Capacities/Limitations	
Date Limitations Began	Next Review Date

Plan Specifications	
Start Date	End Date
Describe modified job and/or specific tasks:	
Describe hours/day and days/week, including progression schedule:	
Special considerations:	

This Transitional Employment Plan has been reviewed and discussed with me to clarify any questions I may have. I have been provided with a copy of this plan and I understand my supervisor will retain a copy. Should I experience any difficulties while performing transitional work, I will immediately contact my supervisor.	
Employee Signature	Date

I have reviewed and discussed this Transitional Employment Plan with the employee. In addition, I have provided a copy of the plan to the employee.	
Supervisor Signature	Date
Department Manager (MPP or Dept. Chair) Signature	Date
Disability Manager	Date

****Footnote:** This employment plan temporarily modifies your regular position description.